06347

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred: 1217 E. Church, st.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 1217 E. Church st (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Richard Adams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie J. Adams
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 13- 1880

8. AGE: Years: 65 | Months: 11 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Amelia Co. Va. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: merchant

FATHER
12. Name: John Richard Adams
13. Birthplace: Va.

MOTHER
14. Maiden name: Susie Hicks
15. Birthplace: Va.

16. Informant: Mrs. Minnie J. Adams
Address: 1217 E. Church St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: June 7-46 (month) (day) (year)
Cemetery or crematory: Blackstone Cem.
Location: Blackstone Negro
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 6/5/1946 (Date received by registrar) Maggie E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1946 at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1946 to June 4 1946 and that I last saw h. i. m. alive on June 4 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Coronary Sclerosis	?
Due to:	
Other conditions: Acute Congestive Heart Failure (Include pregnancy within 3 months of death)	

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Rivers Hanson, M.D. M. D. or other
Address: Salisbury, Md. Date signed 6/5/46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C0346

M

MV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1700)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County W Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Bush St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury R. D. 2 (If outside city or town limits, write RURAL and give nearest town)

Street No. Ocean City Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Gaylon Adkins

3.(b) Social Security Number 212 16 1906

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife Maude Brown Adkins

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) March, 5, 1890

8. AGE: Years	Months	Days	If less than one day
56	3	3	hrs. min.

9. Birthplace Wicomico, Co. Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Joseph E. Adkins
13. Birthplace Wicomico, Co. Md

MOTHER
14. Maiden name Mary C. Brown
15. Birthplace Wicomico Co. Md

16. Informant Mrs. J. Gaylon Adkins
Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 / 11 / 46 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Md

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 6/11 19 46 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 46, at 11 10 a M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19 medical examiner

Immediate cause of death: Broken neck — DURATION: sudden death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 11 10 am

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury: Ran car into concrete wall. Injured at work? no

23. SIGNATURE: J. A. Rademaker MD Deputy Med Examiner M. D. or other

Address Salisbury, Md Date signed 6/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-A)

CERTIFICATE OF DEATH

06349

Reg. Dist. No. 3-29

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County: Dade

City or town: Miami
(If outside city or town limits, write RURAL and give nearest town)

Street No.: N.E. 18½ St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Allender Mr. Clarence Reay

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mollie Bowen Allender

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 14-1872

8. AGE: Years	Months	Days	If less than one day
73	7	16	...hrs. ...min.

9. Birthplace: Morgantown W. Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Construction Engineer

FATHER — 12. Name: Joseph L. Allender

FATHER — 13. Birthplace: Grafton W. Va.

MOTHER — 14. Maiden name: Eliz. Jeff Rosalie Reay

MOTHER — 15. Birthplace: Morgantown W. Va.

16. Informant: Mrs. Mathew Allender Coudrey

Address: Snow Hill Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2-46 (Month) (day) (year)

Cemetery or crematory: Woodlawn Mem.

Location: Baltimore Maryland

18. Funeral director: Holloway & E. Walter R. Holloway

Address: Salisbury Maryland.

19. 7/2/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30th 1946, at 4:25 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Nephritis, Chronic	2 weeks
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Paul Cohen M.D. M. D. or other

Address: Snow Hill Md. Date signed: 7/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06350

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Years

Hospital, Institution, or street address where death occurred:
207 Hazel Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Hazel Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ida Mae Bedsworth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wade H. Bedsworth

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April, 22, 1877

8. AGE: Years	Months	Days	If less than one day
69	2	7	____ hrs. ____ min.

9. Birthplace: Wicomico Co. Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Winder C. Davis
13. Birthplace: Wicomico, Co. Md

MOTHER
14. Maiden name: Not Known
15. Birthplace

16. Informant: J. Marion Bedsworth
Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/1/46 (month) (day) (year)

Cemetery or crematory: Wicomico Memorial Park

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 7/1 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29, 1946, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1946 to June 29 1946 and that I last saw h[illegible] alive on June 28 1946

Immediate cause of death: Cerebral Hemorrhage — DURATION: 1 day

Due to: Hypertension — DURATION: ?

Due to: Arteriosclerosis — DURATION: ?

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Robert Groves M. D. or other

Address: Salisbury, Md. Date signed: 7/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C6351

CERTIFICATE OF DEATH

Reg. Dist. No. 330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico
County
City or town Mardela, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wic
City or town Mardela Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bertha M. Bennett

3. (b) Social Security Number 213-01-1307

4. Sex F
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Leon G. Bennett
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) Nov 13 1890
8. AGE: Years 55 Months 6 Days 29 If less than one day ... hrs. ... min.
9. Birthplace allen Wic Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Ferdinand Smith
13. Birthplace Md
MOTHER 14. Maiden name Emma B. Jones
15. Birthplace Md
16. Informant Leon Bennett
Address Mardela Md
17. Burial Date thereof 6-13-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mardela Md.
Location Mardela, Md
18. Funeral director Graveney Bros
Address Sharptown
19. 6/13/46 19 W. M. Robertson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1946 at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1946, to June 11, 1946 and that I last saw h[illegible] alive on June 11, 1946.

	DURATION
Immediate cause of death Congestive Heart Failure	7
Due to Anasarca Edema	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel H. Seaman M. D. or other
Address 238 Camden Ave Salisbury, Md. Date signed 6-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06352

CERTIFICATE OF DEATH

Reg. Dist. No. 339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Blaine Mr. James Jr

3. (b) Social Security Number: 579-05-1303

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	M

6.(b) Name of husband or wife: Mrs Sarah Blaine

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): May 31-1894

8. AGE: Years: 52 Months: 0 Days: 3 If less than one day: hrs. min.

9. Birthplace: Pocomoke Worcester Md. (Town, county, and state)

10. Usual occupation: Pay Clerk at

11. Industry or business: U.S. Navy Air Base

FATHER 12. Name: Jesse T. Blaine

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Mollie Hargis

MOTHER 15. Birthplace: Md

16. Informant: Mrs Sara Blaine

Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5-1946 (month) (day) (year)

Cemetery or crematory: Presbyterian Cemetery

Location: Pocomoke City Md.

18. Funeral director: Henry Shockley

Address: Pocomoke, Md.

19. 6/5 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1946, at 2 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on 6/3 1946

Immediate cause of death	DURATION
Ruptured Appendix	Unk
Due to Acute Cardiac Dilation	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Appendectomy Date of op. 6/2/1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Date signed 6/5/1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

06353

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: 919 Railroad Ave,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 919 Railroad ave,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Henry Edward Blalock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Ellen Blalock
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): July 2nd 1871

8. AGE:

Years	Months	Days	If less than one day
74	11	5	hrs. min.

9. Birthplace: Stanley C. N. C. (town, county, and state)
10. Usual occupation: Retired Bldg. Contractor
11. Industry or business

FATHER
12. Name: Zachariah D. Blalock
13. Birthplace: Stanley C. N. C.

MOTHER
14. Maiden name: Martha Elizabeth Rummage
15. Birthplace: Stanley C. N. C.

16. Informant: Mr. Martin J. Blalock
Address: 400 Barclay ave, Portsmouth Va

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 10-1946 (month) (day) (year)
Cemetery or crematory: Wico. Mem. Park Salisbury Md
Undertaker: Holloway & Walter R. Holloway

18. Funeral director: Salisbury Maryland
Address:

19. 6/10 1946 Isabelle E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7th 1946 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to June 6 1946
and that I last saw h.. alive on June 6 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Chronic Myocarditis	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md. Date signed 6-8-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Nr Salisbury - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: U.S. #3 Delmar Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Hebron

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Patricia Anne ~~Taylor~~ Boles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 12-1946

8. AGE: Years — Months — Days: one — If less than one day ..... hrs. ..... min.

9. Birthplace: Near Salisbury Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Geo. W. Boles

13. Birthplace: Berlin, Md.

MOTHER

14. Maiden name: Dora Bee Taylor

15. Birthplace: Hebron, Md.

16. Informant: Mother

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 14-46 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

16. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Md.

19. 6/14 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13th 1946 at 4:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Prenatal Examinations Continuously 19 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Preterm Infant	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. T. Fiedler M.D.

Wicomico County Medical Examiner M. D. or other

Address: Salisbury Md. Date signed 6/13/46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-4)

CERTIFICATE OF DEATH

06355

Reg. Dist. No. 233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs
Hospital, institution, or street address where death occurred: P.S. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Inna Mildred Brannock

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Earl E. Brannock
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Jan 5- 1896
8. AGE: Years: 50 Months: 5 Days: 11 If less than one day: hrs. min.
9. Birthplace: Menominee Falls, Wis (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
FATHER 12. Name: — Streeter
FATHER 13. Birthplace: Wis.
MOTHER 14. Maiden name: Anna Shutty
MOTHER 15. Birthplace: Wis.
16. Informant: Mr. Earl E. Brannock Jr.
Address: State Highway Laurel Del.
17. Burial, cremation, or removal. Which? Buried Date thereof June 20-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. (Date rec'd by registrar) 6/19/46 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16th 46 at 305 PM
I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/1/46 to 6/16/46
and that I last saw h... alive on 6/16/46

Immediate cause of death	DURATION
Ca of Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

25. SIGNATURE: J. B. Hall M. D. or other
Address: Salisbury Date signed 6/19/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06356

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico Co
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
1107 Railroad Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1107 Railroad Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Lena Bratten

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James E. Bratten
6.(c) If alive, give age 27 years
7. Birth date of deceased (mo., day, yr.): March 8-1921

8. AGE: Years	Months	Days	If less than one day
25	2	24	hrs. min.

9. Birthplace: Salisbury Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER — 12. Name: Charles S. Davis
13. Birthplace: Laurel Delaware
MOTHER — 14. Maiden name: Lecta V. Layfield
15. Birthplace: Salisbury Md.
16. Informant: Mrs. Alfred Willett
Address: 1107 Railroad Ave, Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4-46 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.
19. 6/4/1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2nd 1946, at 12 22/9 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Subacute Bacterial Endocarditis	9 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: J. Holloway Jr. M.D. Deputy Medical Examiner
Address: Salisbury, Md. M. D. or other
Date signed 6/3/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06357

CERTIFICATE OF DEATH

Reg. Diat. No. 993

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or Street address where death occurred: U.S. Dept.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Franklin st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Matthew Brewington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 8-1898

8. AGE: Years 47 | Months 8 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Siloam (Town), Maryland (State)
Cork

10. Usual occupation

11. Industry or business

FATHER
12. Name: John Brewington
13. Birthplace: Siloam Md.

MOTHER
14. Maiden name: Bettie Washburn
15. Birthplace: Siloam Md.

16. Informant: Mr. Willet F. Brewington
Address: 515 Franklin St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25-46 (month) (day) (year)
Cemetery or crematory: Siloam Cem.
Location: Siloam Maryland.

18. Funeral director: Holloway & Wallace R. Holloway
Address: Salisbury Maryland

19. 6/25/46 (Date rec'd by registrar) Bessie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 1946 at 9.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/16 1946 to 6/23 1946 and that I last saw him alive on 6/23 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Yrs
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE J. M. Neb M. D. or other
Address ..... Date signed 6/25/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Warren

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06358

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: 407 Baker Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 Baker St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosa Emily Buttingham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Woodland Fr. Buttingham

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Feb. 13-1866

8. AGE:

Years	Months	Days	If less than one day
80	4	8	hrs. min.

9. Birthplace: Worcester Co. Md.
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business:

FATHER
12. Name: Randall Tomellen
13. Birthplace: Worcester Co. Md.

MOTHER
14. Maiden name: Adeline Pearl
15. Birthplace: Worcester Co. Md.

16. Informant: Mr. Woodland Fr. Buttingham
Address: 407 Baker st. Salisbury Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof June 25-46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet church Cem
Location: Worcester Co. Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 6-26-1946 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21st 1946 at 3.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19 to June 21 1946
and that I last saw her alive on June 21st 1946

Immediate cause of death: Chronic myocarditis — DURATION: 3 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy Results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Warren M.D.
M. D. or other
Address: Salisbury Date signed June 24

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06359

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs. 35 mins

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Seaford - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Bethel
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Cannon Baby

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

B.(b) Name of husband or wife: —

B.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 24, 1946

8. AGE: Years — Months — Days — If less than one day: 3 hrs. 35 min.

9. Birthplace: Delaware Sussex County (Town, county, and state)

10. Usual occupation: Born en route to Hospital

11. Industry or business:

FATHER — 12. Name: Johnson, Alfonso Leon

13. Birthplace: Delaware

MOTHER — 14. Maiden name: Cannon, Doris Alethea

15. Birthplace: Seaford, Delaware

16. Informant: Sarah O. Cannon

Address: Seaford, Delaware R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 1946 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Near Federalsburg, Maryland

18. Funeral director: K.K. Frampton and Son

Address: Federalsburg, Maryland

19. 6/24/46 (Date rec'd by registrar) Laggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/24 1946, at 6:45 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 24 1946 to June 24 1946

and that I last saw him alive on June 24 1946

Immediate cause of death	DURATION
Respiratory failure	15 min.
Due to: Cardiac insufficiency	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. K. Starr M. D. or other

Address: Salisbury, Md Date signed 6-24-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

06361

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 10 years

Hospital, institution, or street address where death occurred: No

How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Ida Cartier

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	Single

6.(b) Name of husband or wife: No

8.(c) If alive, give age: No years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1878

8. AGE: Years: 67 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Philadelphia, Pa (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: Same as above

FATHER

12. Name: Nathaniel Cartier

13. Birthplace: accomac, Virginia

MOTHER

14. Maiden name: Abbie Cartier

15. Birthplace: Philadelphia, Pa.

16. Informant: Emlen Elzey

Address: Nanticoke, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Eden

Location: Philadelphia, Pa

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md.

19. June 4 1946 (Date rec'd by registrar) R. Woolford Walton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-3-46 19 at 7.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-3-46 only visit 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Arteriosclerosis	
Due to: Senility.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert J Lore MD

M. D. or other

Address: Nanticoke, Md Date signed 6-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

06360

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nellie Nichols Cockell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: Major Lee Cockell
8.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): May 16, 1895.

8. AGE:

Years	Months	Days	If less than one day
51	5	30	...hrs. ...min.

9. Birthplace: Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:

FATHER
12. Name: Chas. H. Nichols
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Sophia Simms
15. Birthplace: Wicomico Co. Md.

18. Informant: Major Lee Cockell
Address: Allen, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/46 (month) (day) (year)
Cemetery or crematory: Allen Methodist
Location: Allen, Md.
18. Funeral director: Ne. Hill & Johnson Co.
Address: Salisbury, Md.

19. 6/11/46 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9, 1946 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1946, to June 9, 1946, and that I last saw h.. alive on June 9, 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	?
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Yeaman M.D.
M. D. or other
Address: 238 Camden Ave., Salisbury, Md. Date signed 6/11/46.

MARYLAND STATE DEPARTMENT OF HEALTH

06362

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: P.H. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Nan A. Selliton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Leon Selliton
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): Nov. 4 - 1885

8. AGE: Years	Months	Days	If less than one day
60	7	17	hrs. min.

9. Birthplace: Stockton Worcester Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Harry J. Merritt
13. Birthplace: Maryland
MOTHER 14. Maiden name: Susan E. Marshall
15. Birthplace: Maryland
16. Informant: Mr. Leon Selliton
Address: Stockton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23/46 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Stockton, Md
16. Funeral director: Deane & Dennis
Address: Snow Hill, Md
19. 6/22/1946 (Date rec'd by registrar) Harry T. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1946 at 2 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to June 21 1946
and that I last saw her alive on June 21, 1946
Immediate cause of death: Decompensated hypertensive cardio-vascular renal disease — DURATION: 6 mo
Due to: Diabetes mellitus — unknown
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Chen MD M. D. or other
Address: Snow Hill Date signed 6/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06363

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Jesterville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Jesterville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Jennie H Conway

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A.A.	Widow

6.(b) Name of husband or wife: Hagan Conway

Dead 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.): about 1876

8. AGE: Years: About | Months | Days | If less than one day: hrs. min.

9. Birthplace: Jesterville Md
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Same as above

FATHER
12. Name: Arnold Lankford
13. Birthplace: Wetipquin Md

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Thomas Conway

Address: Jesterville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27 1946 (month) (day) (year)

Cemetery or crematory: Edgy

Location: Jesterville Md

18. Funeral director: James F. Stewart

Address: Salisbury Md

19. 6/27 1946 (Date rec'd by registrar) R.N. Dallin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23rd 1946, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15th 1944, to June 23rd 1946

and that I last saw h[illegible] alive on June 19th 1946

Immediate cause of death	DURATION
Chronic Myocarditis	6 months
Due to: Cerebral Haemorrhage	18 months
Due to: Hypertensive	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eedor L. Mavroman M. D. or other

Address: Princess Anne Md Date signed: 6-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06364

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: Lenora Mae Cox

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife: Warren H. Cox
B.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	7	4		

9. Birthplace: Dishing Creek, Dorchester, Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business ✓

FATHER
12. Name: William Hallett
13. Birthplace: Dorchester Co. Md.

MOTHER
14. Maiden name: Lena Simmons
15. Birthplace: Dorchester Co. Md.

16. Informant: Marvin C. Cox
Address: Nanticoke, Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof 6/27/46 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Nanticoke, Md.

18. Funeral director: E. Pell Wilson Co.
Address: Salisbury, Md.

19. 6/24, 1946 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20, 1946, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw her alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Embolism	2 days
Due to Carcinoma of head of Pancreas.	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert Lore M.D. M. D. or other
Address: Nanticoke, Md. Date signed: 6-24-46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164

CERTIFICATE OF DEATH

★ 06365

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Siloam

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury R.D. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Siloam

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Samuel James Disharoon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Twalie B. Disharoon

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 28, 1893

8. AGE: Years	Months	Days	If less than one day
52	11	24	...hrs. ...min.

9. Birthplace: Wicomico co, Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Samuel James Disharoon

FATHER 13. Birthplace: Somerset co. Md

MOTHER 14. Maiden name: Annie Insentley

MOTHER 15. Birthplace: Somerset co. Md

16. Informant: Mrs Samuel J. Disharoon

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/6/46 (month) (day) (year)

Cemetery or crematory: Siloam Cemetery

Location: Siloam Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury Md

19. 6/10/1946 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1946, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Accidental Poisoning to date

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Accidental Poisoning of	
Chest (Suicide)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 6/4/46

Where did injury occur? near Salisbury Wicomico Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Accidental Poisoning Injured at work?

23. SIGNATURE: Elmer T. Tucker M.D. Deputy medical examiner, M. D. or other

Address: Salisbury Md Date signed 6/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06366

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Worcester

City or town [illegible] (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, institution, or street address where death occurred: Montcoke

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Worcester

City or town Montcoke (If outside city or town limits, write RURAL and give nearest town)

Street No. ✓ (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Lloyd Allen Fields

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Dorothy Parker Fields

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) March 3, 1898.

8. AGE: Years	Months	Days	If less than one day
48	3	20	...hrs. ...min.

9. Birthplace Lawsinteg, Scotland N.C. (Town, county, and state)

10. Usual occupation Medical Doctor

11. Industry or business ✓

FATHER 12. Name Jones D. Fields

FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden name Belle Tessier

MOTHER 15. Birthplace South Carolina

16. Informant Mrs. D. Allen Fields, Address Montcoke, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6 25 46 (month) (day) (year)

Cemetery or crematory Pines

Location Montcoke, Md.

16. Funeral director McKell & Benson Co.

Address Salisbury, Md.

19. June 25 19 46 R. Wayford Potter (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1946, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h[illegible] alive on ...19...

Immediate cause of death	DURATION
Respiratory Failure	3 hrs.
Due to Cerebral Hemorrhage	4 hrs.
Due to Essential Hypertension	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Robert Gore MD M. D. or other

Address Montcoke Md Date signed 6-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (752)

CERTIFICATE OF DEATH

★ 06367 Reg. Dist. No. 3-33

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Gen. Gen. Hospital.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alfred Good

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 60			..... hrs. ..... min.

9. Birthplace: Shepard town Va. (Town, county, and state)
10. Usual occupation: Night watchman
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Mr. Gordon Hastings
Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/21/40 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin md

18. Funeral director: Adam A. Burbage
Address: Berlin md

19. 6/21/40 (Date rec'd by registrar) 1940 Harriet E. Dickson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1940, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Concussion of brain	
Due to: Fracture of Skull	5 days
Due to: unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Autopsy results: Linear fracture left parietal bone
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: unknown Date of June 14 '40
Where did injury occur? Berlin (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?) Not known
Means of injury unknown Injured at work? No

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other
Address: Berlin Md Date signed June 20 '40

VS A15 9-45-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06368

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 7-15 9-45-1

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital, Salisbury

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Walnut St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dr. Robert Lee Hall

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary E. Hall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21st 1877.

8. AGE: Years	Months	Days	If less than one day
68	11	29	..... hrs. ..... min.

9. Birthplace: Marion Station Somerset Co Md
(Town, county, and state)

10. Usual occupation: Physician

11. Industry or business

FATHER
12. Name: John W. Hall
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary E. Coulbourne
15. Birthplace: Md

16. Informant: Mary E. Hall
Address: Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23d 46 (month) (day) (year)

Cemetery or crematory: Presbyterian

Location: Churchville, Md.

18. Funeral director: Evangeline A. Watson

Address: Pocomoke City, Md.

19. June 21 1946 Harriet E. Johnson Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20th 1946, at 3.00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24th 1946, to June 20th 1946, and that I last saw him alive on June 20th 1946

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions: Acute Rheumatitis	4 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Acute Rheumatitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Olan T. Fisher M.D.
M. D. or other

Address: Salisbury Md. Date signed 6/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

06369

CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH:
County Wicomico P. G. Hospital
City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State County Som
City or town Deals Island
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Julia Harrison

3. (b) Social Security Number

4. Sex F
5. Color or race Whit
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Wm H. Harrison
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feby 1877
8. AGE: Years 69 Months Days If less than one day hrs. min.
9. Birthplace Deal Island Md (Town, county, and state)
10. Usual occupation Housedutie
11. Industry or business —
FATHER 12. Name Geo. W. Abbott
13. Birthplace Deal Island Md
MOTHER 14. Maiden name Louise Webster
15. Birthplace Deal Island Md
16. Informant Mrs Keron Abbott
Address Deal Island Md
17. Burial Date thereof 6/25-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Deal Island M.E.
Location Deal Island Md
18. Funeral director L G Webster
Address Deal Island Md
19. 6/25/46 (Date rec'd by registrar) 1946 Harriet E. Johnson Deal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1946, at 1 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19 , to June 24 1946
and that I last saw h alive on June 23 1946

Immediate cause of death	DURATION
Chro valvular heart dis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. R. Warner M.D. M. D. or other
Address Salisbury Date signed June 25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

06370

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 1404 Russell avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 1404 Russell av. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Olevia Catherine Hastings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Hastings

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 23-1866

8. AGE:

Years	Months	Days	If less than one day
80	1	19	____ hrs. ____ min.

9. Birthplace: Wicomico County, Md. (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Home

FATHER 12. Name: John Benj. Heam

FATHER 13. Birthplace: Wicomico County, Md.

MOTHER 14. Maiden name: anna Heam

MOTHER 15. Birthplace: Wicomico County, Md.

16. Informant: Mrs Bessie Burnett

Address: 1404 Russell av. Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-13-46 (month) (day) (year)

Cemetery or crematory: Mt. Olive Methodist

Location: Delmar, Delaware

18. Funeral director: H. S. Ingard Co

Address: Delmar, Delaware

19. 6/12/1946 (Date rec'd by registrar) Harriet E. Johnson (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1946, at 2.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1946, to June 11 1946 and that I last saw h[illegible] alive on June 11 1946

	DURATION
Immediate cause of death: Uremia Coma	48 hrs
Due to: Chronic Nephritis	9 weeks
Due to:	
Other conditions: Carcinoma of sigmoid (Probable)	6 mo

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Rademaker M.D. M. D. or other

Address: Salisbury, Md Date signed: 6/12/46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-a

CERTIFICATE OF DEATH

06371

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
P.G. Hospital — Salisbury, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town White Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John R. Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	widower

6.(b) Name of husband or wife Jennie Hughes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 20 — 1871

8. AGE:

Years	Months	Days	If less than one day
75	4	20	..... hrs. ..... min.

9. Birthplace White Haven, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name Isaac Hughes

FATHER 13. Birthplace White Haven, Md.

MOTHER 14. Maiden name Mirit Brown

MOTHER 15. Birthplace ~

16. Informant Alice Foster

Address 210 W. 149th St. Phila. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 1946 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location near Messicks store

18. Funeral director C.E. Messick

Address Bivalve, Md.

19. 6/13, 1946 (Date rec'd by Registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1946 at 8:37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1946 to June 10 1946 and that I last saw h. L.M. alive on June 10 1946

Immediate cause of death	DURATION
Pulmonary edema secondary to Cardiac failure	6 hrs.
Due to Intestinal obstruction	2 days
Due to Volvulus and Intestinal hernia lower abdom.	2 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Volvulus, gangrenous hernia, obstructive Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William B. Long M.D.
M. D. or Coroner

Address 504 W. Dunkin St. Date signed June 12/1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06372

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.B. Wright
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Holt Kenney

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Ida Harting Kenney
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): July 12- 1880
8. AGE: Years: 65 Months: 10 Days: 22 If less than one day: hrs. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Sec. & Pgrin Cofa
11. Industry or business: Bottling Co. Salisbury Md
12. FATHER — Name: George P.K. Kenney
13. Birthplace of ~~Father~~ ~~Mother~~ and Mother: Delaware
14. MOTHER — Maiden name: Anna Holt
15. Birthplace: Seaford Delaware
16. Informant: Mrs Willie Jarman
Address: Seaford Delaware
17. Burial: (Burial, cremation, or removal. Which?) Date thereof: June 7-46 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland
19. 6/6 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4th 1946 at 8:35 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1943, to JUNE 4 1946
and that I last saw h.. alive on JUNE 4 1946
Immediate cause of death: Coronary Occlusion, Acute — DURATION
Due to: Coronary Sclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Steve Hanson M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 6/5/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06373

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Camden Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sewis, Miss Elizabeth Ann.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27- 1936

8. AGE: Years 9 | Months 11 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William A. Lewis

13. Birthplace Pillards Md

MOTHER 14. Maiden name Beatrice Murray

15. Birthplace Sussex Co. Del

16. Informant Mrs. Beatrice Lewis

Address 217 Camden ave. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 20 46 (month) (day) (year)

Cemetery or Crematory Lewis Cem.

Location Pillards Md

18. General director Hollaway & Walter P. Holloway

Address Salisbury Md.

19. 6/19/1946 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18- 1946, at 1 28 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 June 1946, to 18 June 1946 and that I last saw h.. alive on 17 June 1946

Immediate cause of death	DURATION
Tuberculous meningitis	25 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results ..... none .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jack Kues, M.D. M. D. or other

Address Salisbury, Md. Date signed 18 June '46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06374

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury R. D. 3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, Institution, or street address where death occurred:
Ocean City Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury R. D. 3
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Jennie Long

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John H. Long

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1855

8. AGE: Years	Months	Days	If less than one day
90	6	4	hrs. min.

9. Birthplace Denton, Caroline, Co. Md
(Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name Henry Hennie

13. Birthplace Maryland

MOTHER 14. Maiden name Not know

15. Birthplace

16. Informant Mr. Ernest B. Long

Address 1627 Montpelr St. Balto. Md

17. Burial Date thereof 6 / 1 / 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parson Cemetery

Location Salisbury, Md

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 7/1/46 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1946, at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to June 29 1946 and that I last saw h[illegible] alive on June 6 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. Gray, M.D. M. D. or other

Address Salisbury, Md Date signed 7/1/46

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (925)

CERTIFICATE OF DEATH

06375

Reg. Diat. No. 11 336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County Wicomico

City or town Delmar (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84years

Hospital, Institution, or street address where death occurred: RFD # 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # L (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George William Oliphant

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) August 29, 1881

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace Sussex County, Del. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name Thomas Oliphant

13. Birthplace Sussex County, Del.

MOTHER 14. Maiden name Priscilla Hastings

15. Birthplace Sussex County, Del.

16. Informant Mrs Norman Hastings

Address Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-5-46 (month) (day) (year)

Cemetery or Crematory Oliphant

Location Delmar, Del. RFD

18. Funeral director W. S. Isaacs Co

Address Delmar, Delaware

19. June 5, 1946 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1946, at 11 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 1945, to June 2nd 1946

and that I last saw h... alive on June 1st 1946

Immediate cause of death Embolism Right cerebral artery — DURATION 2 days

Due to

Due to

Other conditions Valvular heart disease ? Hypertension. (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Tobler M.D. M. D. or other

Address 1 E. 7th Street Delmar Del. Date signed 6-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06376

CERTIFICATE OF DEATH

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 years
Hospital, Institution, or street address where death occurred: Pasadena
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne's
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Emma Estelle Pasons

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: E. Elmer Pasons
8.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1879.

8. AGE: Years	Months	Days	If less than one day
66	8	19	...hrs. ...min.

9. Birthplace: Pasadena, Queen Anne's, Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: ✓

FATHER
12. Name: Asbury N. Perdue
13. Birthplace: Queen Anne's Co., Md.

MOTHER
14. Maiden name: Mary E. Bailey
15. Birthplace: Queen's Co., Md.

16. Informant: E. Elmer Pasons
Address: Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/23/46. (month) (day) (year)
Cemetery or crematory: Methodist
Location: Pasadena, Md.

18. Funeral director: De Hill & Howes Co.
Address: Salisbury, Md.

19. 6/22, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1946, at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...1946, to ...1946, and that I last saw h... alive on June 20 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Fred L. Seamon M.D. M. D. or other
Address: Salisbury, Md. Date signed 6-21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06377

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Willards Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Martha Lillian Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14, 1905

8. AGE: Years: 41 | Months: 1 | Days: 29 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Willards, Wicomico Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: —

FATHER
12. Name: Joseph Ernest Phillips
13. Birthplace: Md.

MOTHER
14. Maiden name: Stella Kate Baker
15. Birthplace: Md.

16. Informant: Mrs. L. R. Phillips
Address: Willards, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/14/46. (month) (day) (year)
Cemetery or crematory: Bethel
Location: near Willards, Md.

18. Funeral director: M. Pusha Watson
Address: Salisbury, Md.

19. 6/14 1946 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to day of death 1946
and that I last saw her alive on 6-7-46 1946

	DURATION
Immediate cause of death: Pulmonary tuberculosis	3 yrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank R. Lewis MD
M. D. or other
Address: Willards Md Date signed June 12 '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06378 Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Rhodes Hudson Allen Knox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1946

8. AGE: Years | Months | Days | If less than one day: 4 hrs. min.

9. Birthplace: Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Allen Knox Rhodes
13. Birthplace: West Carolina

MOTHER
14. Maiden name: Elsie Fraser
15. Birthplace: East Carolina

16. Informant: Allen Knox Rhodes
Address: P.O. Box 4, Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/24/46 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.

18. Funeral director: Ke Nill & Hanson Co.
Address: Salisbury, Md

19. 6/21/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1946 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1946, to June 20 1946 and that I last saw him alive on June 20 1946.

	DURATION
Immediate cause of death: PREMATURITY	
Due to: ABRUPTIO PLACENTA	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. Rivers Hanson M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 6/21/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06379

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville (If outside city or town limits, write RURAL and give nearest town)
Street No. ✓ (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Lillian S. Riall

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife ✓
6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1894.

8. AGE: Years 52 | Months 4 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace: Pittsville, Wicomico, Md. (Town, county, and state)
10. Usual occupation: At Home ✓
11. Industry or business

FATHER
12. Name: John Wilson Riall
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Ella Parks
15. Birthplace: Wicomico Co., Md.

16. Informant: Miss E. Pauline Riall
Address: Salisbury, Md.

17. Buried (Burial, cremation, or removal, Which?) Date thereof 6/18/46. (month) (day) (year)
Cemetery or crematory: St Mary's Episcopal Church
Location: Pittsville, Md.

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.

19. 6/21/46. (Date rec'd by registrar) Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1946, at 11.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1946, to June 16 1946 and that I last saw h.. alive on June 15 1946

	DURATION
Immediate cause of death: Right Ventricular failure	16 hrs
Due to: Biliary Cirrhosis of Liver	—
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Robert Lane M.D. M. D. or other
Address: Pittsville, Md. Date signed 6-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06380

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Quantico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 24 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Quantico

City or town: Quantico md (If outside city or town limits, write RURAL and give nearest town)

Street No.: no (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME Emma L Rider

3.(b) Social Security Number Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	married

6.(b) Name of husband or wife: Charles Rider

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): Feb 20 1884

8. AGE: Years	Months	Days	If less than one day
62	4	1	hrs. min.

9. Birthplace: Milford va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER 12. Name: Henry Hatsun

FATHER 13. Birthplace: Milford va.

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Elsie Jones

Address: Quantico md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 23 /46 (month) (day) (year)

Cemetery or crematory: Quantico

Location: Quantico md

18. Funeral director: James L. Stewart

Address: Salisbury md

19. June 24 1946 (Date rec'd by registrar) Jno Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1946 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946 to June 21 1946 and that I last saw h alive on June 20 1946

Immediate cause of death	DURATION
Circulatory failure	
Due to: Left ventricular failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J Purnell, M.D. M. D. or other

Address: 800 D. Main Date signed: 6-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06381

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: John B. Parsons Home
How long in hospital or institution? 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. High & Bush St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robinson, Charlotte Ann

3.(b) Social Security Number: ✓

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: John P. Robinson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 15, 1859.

8. AGE: Years 86; Months 9; Days 6; If less than one day ... hrs. ... min.

9. Birthplace: Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: George Gibbs
13. Birthplace: Worcester Co. Md.

MOTHER
14. Maiden name: Charlotte Bevans
15. Birthplace: Worcester Co. Md.

16. Informant: Office John B. Parsons Home
Address: Salisbury, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 27, 1946
(month) (day) (year)
Cemetery or crematory: Good Hill Cemetery
Location: Worcester Co. Md.

18. Funeral director: Lee Hill & Johnson Co.
Address: Salisbury, Md.

19. 6/22 1946 Lessie E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 - 21 1946 at 8 30/9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...
Medical examiner on call

Immediate cause of death: Coronary Thrombosis
DURATION: sudden death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M.D.
Deputy Med Examiner
M. D. or other
Address: Salisbury, Md. Date signed: 6/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06382

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Westfingum Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: md County: Wicomico

City or town: Westfingum md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME Louise Seldon

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A.A.	Widow

6.(b) Name of husband or wife: Joseph Seldon

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1866

8. AGE: Years: about 80 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Westfingum Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home Goodness

FATHER 12. Name: Stephen Cook

FATHER 13. Birthplace: Westfingum, md.

MOTHER 14. Maiden name: Martha Wright

MOTHER 15. Birthplace: Westfingum md

16. Informant: Mrs Edith Button

Address: Westfingum Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19-46 (month) (day) (year)

Cemetery or crematory: Odd Fellows

Location: Westfingum, Md.

18. Funeral director: James A. Stewart

Address: Salisbury Md

19. 6/18 1946 (Date rec'd by registrar) K. Basford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to June 16 1946 and that I last saw h[illegible] alive on June 16 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	48 hr.
Due to: Arterio sclerosis.	2 yr.
Due to: Senility	2 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Shore MD
M. D. or other

Address: Westfingum, Md. Date signed: 6-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

06383

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred: P.B. Hoyt.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 113 E. Locust St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Frances Semeler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Anthony Richard Semeler
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Oct. 3rd 1907

8. AGE:

Years	Months	Days	If less than one day
38	8	5	...hrs. ...min.

9. Birthplace: Scranton, Pa. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
FATHER 12. Name: William Graham
FATHER 13. Birthplace: Lancashire England
MOTHER 14. Maiden name: Lucy Caddy
MOTHER 15. Birthplace: Lancashire England
16. Informant: Mr. Anthony R. Semeler
Address: 113 E. Locust St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11th 1946 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury, Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland
19. 6/11/1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8th 1946, at 10.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946 to June 8 1946
and that I last saw h... alive on June 8 1946

Immediate cause of death	DURATION
Due to: Cardio vascular Renal disease.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth A. Insley M. D. or other
Address: 801 S. Clarke Rd. Date signed 6-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06384

CERTIFICATE OF DEATH

Reg. Diat. No. 44 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
San Domingo

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Von V. Smiley

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 25, 1945

8. AGE: Years	Months	Days	If less than one day
1	0	19	hrs. min.

9. Birthplace Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

FATHER 12. Name Frank M. Smiley

13. Birthplace Wicomico County, Maryland

MOTHER 14. Maiden name Bloie Hoington

15. Birthplace Sussex County, Delaware

16. Informant Mrs. Frank M. Smiley

Address Mardela Springs Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16 1946 (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J. J. Frampton and Son

Address Fredericksburg, Maryland

19. June 16 1946 (Date rec'd by registrar) J. D. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1946 at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1946 to June 14 1946 and that I last saw h[illegible] alive on June 14 1946

Immediate cause of death	DURATION
Lobar Pneumonia	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Kuhlman M. D. or other

Address Sharptown Md Date signed 6/16/46

VS A15 9-45-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Moyer

MAGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06385

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Del. County Sussex

City or town Lewes (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Spicer Mrs Lottie M.

3. (b) Social Security Number None

4. Sex Female

5. Color or race W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mr. Elmer J. Spicer

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec 15 1897

8. AGE: Years 48 Months 5 Days 20 If less than one day hrs. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James A. Huey

13. Birthplace Delaware

MOTHER 14. Maiden name Evelyn Morgan

15. Birthplace Delaware

16. Informant Elmer J. Spicer

Address Lewes Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6-46 (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location Lewes Del

18. Funeral director J. Hardy Williamson

Address Fruitland Md

19. 6/6 (Date rec'd by registrar) 19 46 Harold L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1946, at 7:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1945, to June 1946

and that I last saw her alive on June 4 1946

	DURATION
Immediate cause of death Hypertensive Cardio-Vascular Dis.	3 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lee L. Lawry, M.D. M. D. or other

Address Fruitland Date signed 6-4-46

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

CERTIFICATE OF DEATH

(St.) 06386 Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Hyattsville Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: no (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Stanford Bessie

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	✓

6.(b) Name of husband or wife: Boston Stanford

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo. day. yr.): June 6 1925

8. AGE: Years	Months	Days	If less than one day
21	0	24	..... hrs. ..... min.

9. Birthplace: Hyattsville, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER 12. Name: Loyd Lindley

FATHER 13. Birthplace: Va.

MOTHER 14. Maiden name: Ethell Williams

MOTHER 15. Birthplace: Norfolk Va.

16. Informant: Boston Stanford

Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3-1946 (month) (day) (year)

Cemetery or crematory: Mt Olivett

Location: Hyattsville Md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 7/2 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1946 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to: Gumma of Heart due to Syphilis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William D. Gray M.D. M. D. or other

Address: Salisbury Md Date signed: 7/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06387

CERTIFICATE OF DEATH

★ Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico Co
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred: 124 Lincoln Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 Lincoln Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Robert Tindale

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Martha Dixon Tindale
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): April 13th 1863

8. AGE:

Years	Months	Days	If less than one day
83	2	11	..... hrs. ..... min.

9. Birthplace: Pittsville Md.
(Town, county, and state)
10. Usual occupation: retired
11. Industry or business: Carpenter & Farmer
FATHER 12. Name: George Tindale
13. Birthplace: Pittsville Md.
MOTHER 14. Maiden name: Mary Hamblin
15. Birthplace: Sussex Co. Del.
16. Informant: Mrs. Sarah F. Pruitt
Address: 124 Lincoln Ave. Salisbury Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof June 26-46 (month) (day) (year)
Cemetery or crematory: Mango Cem
Location: Mango Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 6/26/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24th 46 at 2.a.m.
I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 20 46 to Jun 27 46
and that I last saw him alive on June 23 46
Immediate cause of death: Cerebral Hemorrhage
Due to: Hypertension
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION: 1 week
Gabon

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas R. Moore M. D. or other
Address: Salisbury Md Date signed: 6/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age of deceased is shown on FILM No. I 06 AUG 23 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06388

Reg. Dist. No. 327

1. PLACE OF DEATH:
County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
Nanticoke, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Henry Travers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widower

6.(b) Name of husband or wife Isola B. Travers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1869

8. AGE: Years	Months	Days	If less than one day
76 77	6	29	..... hrs. ..... min.

9. Birthplace Nanticoke, Wicomico, Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Edward Travers
13. Birthplace Nanticoke, Md.

MOTHER
14. Maiden name Margaret Messick
15. Birthplace Nanticoke, Md.

16. Informant Edward Travers
Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/46 (month) (day) (year)
Cemetery or crematory Travers cemetery
Location Nanticoke, Md.
18. Funeral director L. B. Messick
Address Bivalve, Md.

19. 6/27 (Date rec'd by registrar) 19 46 R. Wofford Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1st 1946, to June 24th 1946
and that I last saw h.. alive on June 24 1946

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William E. Merrick M. D. or Other
Address Helen - Md. Date signed June 24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06389

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred: 405 Martin St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 Martin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Elmer Waller
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mamie Waller
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): May 12 1880
8. AGE: Years 64 Months 0 Days 28 If less than one day ..... hrs. ..... min.
9. Birthplace: Concord Delaware (Town, county, and state)
10. Usual occupation: Box Maker
11. Industry or business: at Box Factory
FATHER 12. Name: George E. Waller
FATHER 13. Birthplace: Sussex Co. Del.
MOTHER 14. Maiden name: Rebecca Phillips
MOTHER 15. Birthplace: Sussex Co. Del.
16. Informant: Mrs. Mamie Waller
Address 405. Martin st. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof June 4- 1946 (month) (day) (year)
Cemetery or crematory Parsons Sign.
Location Salisbury Md.
18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Maryland.
19. 6/4/ 1946 (Date rec'd by registrar) Chas. A. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1946 at 1.21 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to June 2 1946
and that I last saw him alive on June 1 1946
Immediate cause of death Pulmonary Tbc.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Hugh A Insley M. D. or other
Address Salisbury Md Date signed 6-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

D. Nash.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34a)

CERTIFICATE OF DEATH

06390

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Whitmore, Mrs. Evelyn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	

6.(b) Name of husband or wife Whitmore Mr. Norman E.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1906

8. AGE: Years	Months	Days	If less than one day
39	7	5	..... hrs. ..... min.

9. Birthplace Phila. Pa.
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business

FATHER
12. Name Morris Phipps
13. Birthplace Penn.

MOTHER
14. Maiden name Eva Davis
15. Birthplace Maryland

16. Informant Mrs. Norman Whitmore
Address Berlin Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6/27/46 (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin Md
18. Funeral director Anna B. Bunting
Address Berlin Md

19. 6/27 1946 Received by E. S. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946, at 12 54 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/17 1946 to 6/25 1946 and that I last saw her alive on 6/25 1946

Immediate cause of death	DURATION
Kidney stone case.	
Due to Pyelonephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Gall Date of op. 6/15/46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Nash M. D. or other
Address Salisbury Date signed 6/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★06391

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 days

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Mount Vernon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Winder, Frankie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	

6.(b) Name of husband or wife: Unmarried

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE:

Years	Months	Days	If less than one day
73	6	1	..... hrs. ..... min.

9. Birthplace Mt Vernon, Somerset Co, Md

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER

12. Name Daniel Winder

13. Birthplace Somerset Co Md.

MOTHER

14. Maiden name Louise Harris

15. Birthplace Mount Vernon Md

16. Informant Brother

Address Rte. 2 Somerset Co. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6-5-46 (month) (day) (year)

Cemetery or crematory Cemetery

Location Mt Vernon Somerset Co. Md

18. Funeral director Edwin Jones

Address Rte 2. Box 62 Princess Anne Md

19. 6/6 1946 (Date rec'd by registrar) Charles E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1946, at 6.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/30 1946 to 6/7 1946 and that I last saw ~~her~~ alive on 6/7 1946

Immediate cause of death	DURATION
Asthenia Senility	
Renal Insufficiency	
Due to	
~	
Due to	
~	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Pneumonia Date of op. 6/10/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Salisbury Date signed 6/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15